PETITION FOR CHANGE OF PHYSICIAN

Employee Name and Address: Telephone Number: Social Security Number:	Employer Name and Address:
Current Physician and Address:	Surety Name and Address (if known):
Requested Physician and Address:	Additional Information or Documentation Attached (Circle One): No Yes

Date of Injury/Disease: _____

General Information: _____

_____

Medical Treatment to Date: _____

_____

_____

Reason for Change: _____

_____

Hearing Date/Time Availability Next 30 Days: _____

Date: _____ Signature: _____

Typed/Printed Name: _____

ORIGINAL TO EMPLOYER OR SURETY

Copy to Idaho Industrial Commission, 317 Main St., PO Box 83720, Boise, ID 83720-0041, or fax to 208-332-7558.

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of _____, 20___, I caused to be served the Original Petition for Change of Physician upon either the following Employer or its Surety:

EMPLOYER'S NAME AND ADDRESS		SURETY'S NAME AND ADDRESS
_____	OR	_____
_____		_____
_____		_____
via:		via:
( ) Personal Service of Process		( ) Personal Service of Process
( ) Regular U. S. Mail		( ) Regular U.S. Mail

I also hereby certify that on the _____ day of _____, 20___, I caused to be served a true and correct copy of the foregoing Petition for Change of Physician upon:

Idaho Industrial Commission
317 Main Street
Post Office Box 83720
Boise, Idaho 83720-0041

via: ( ) Personal Service of Process

( ) Regular U. S. Mail

( ) Faxed to 208-332-7558

_____
Signature

_____
Typed or Printed Name